STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C  A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY  COMPLETED	
		155625	B. WING		08/07/2012
	OVIDER OR SUPPLIER	2	1021 E	ADDRESS, CITY, STATE, ZIP CODE E CENTRAL AVE NSBURG, IN 47240	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
TAG F0000	This visit was for complaint number complaint number unsubstantiated,  Unrelated deficit facility number:  Provider number Aim:  Survey team: Sharon Lasher R  Census bed type SNF/NF: 74  Total: 74  Census payor type Medicare: 8  Medicaid: 60  Other: 6  Total: 74  Sample: 9  These deficienci	or the investigation of the investigation of the IN00113312.  Der IN00113312, due to lack of evidence.  Hency cited  August 6 and 7, 2012  1000305  155625  100287200		The creation and submission this plan of correction does not consitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credibial allegation and requests a des review in lieu of a Post Complement Survey Revisit on or after Aug 25, 2012.	of ot state of the

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 08/30/2012 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COMP 08/07	E SURVEY LETED 7/2012
	PROVIDER OR SUPPLIE GROVE VILLAGE		1021 E	ADDRESS, CITY, STATE, ZIP COI CENTRAL AVE ISBURG, IN 47240	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIES SICY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	Quality review of Cathy Emswille	r RN				

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Event ID: 2E1S11

Facility ID: 000305

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	A (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	NNG	00	COMPLETED	
		155625	B. WING			08/07/	2012
			B. WING	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
ADDOD (					CENTRAL AVE		
ARBUR	GROVE VILLAGE			GREEN	ISBURG, IN 47240		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0164	483.10(e), 483.75	5(I)(4)				·	
SS=D	PERSONAL PRI\	/ACY/CONFIDENTIALITY					
	OF RECORDS						
		the right to personal					
		dentiality of his or her					
	personal and clini	ical records.					
		includes accommodations,					
		t, written and telephone					
		personal care, visits, and					
		y and resident groups, but					
	private room for e	uire the facility to provide a					
	private room for e	acii residerit.					
	Except as provide	ed in paragraph (e)(3) of					
		esident may approve or					
		e of personal and clinical					
		dividual outside the facility.					
	,	,					
	The resident's rig	ht to refuse release of					
	personal and clini	ical records does not apply					
	when the residen	t is transferred to another					
		ition; or record release is					
	required by law.						
		keep confidential all					
		ined in the resident's					
		ss of the form or storage					
	•	when release is required by					
		er healthcare institution;					
		syment contract; or the					
	resident.	and the substitute of the	F016	.		.,,	00/05/0010
		review and interview the	F016	4	- what corrective action(s)	WIII	08/25/2012
	_	protect 1 resident's			be accomplished for those		
	privacy and conf	identiality, in that a			residents found to have been affected by the deficient praction		
	picture of one rea	sident's leg was taken by			ancoled by the delicient practi	,	
	-	e picture was sent to			The two CNA's involved were		
		ell phone. This deficient			terminated from the facility. The	ne	
					family and physician of the		
	•	1 resident of 9 residents			affected resident were notified		
	reviewed for per	sonal privacy and			The affected was unaware the		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2)		(X2) MUI	(X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE S	(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLET			ETED	
		155625	A. BUILL B. WING			08/07/2	2012
			B. WING	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIE	R					
ARBOR (	GROVE VILLAGE		1021 E CENTRAL AVE GREENSBURG, IN 47240				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	P	REFIX			COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	confidentiality i	n a sample of 9.			incident occurred and the incident	II	
	(Resident #D)				has had no negative effects of		
					the affected residents psychosocial well-being.		
	Findings include	2:			psychosocial well-beilig.		
	1 111411185 1114144	•					
	During on inters	view on 8/7/12 at 10:00			- how other residents hav	ing	
	_				the potential to be affected by		
	· ·	istrator indicated she had			same deficient practice will be	:	
		x #2 and CNA #3			identified and what corrective		
	-	indicated CNA #1			action(s) will be taken;		
	informed her of	a picture that was taken			All residents are at risk of beir	, a	
	of Resident #D's	s left upper thigh. After			affected by the alleged deficie		
	investigating it	was found CNA #2			practice. Staff was in-serviced		
	showed CNA #1	a picture on her cell			regarding cell phone, resident		
		e on Resident #D's upper			rights, and photograph policies	s on	
	_	indicated she held			8/15/2012 by Director of Nursi	ing	
	_	g while CNA #2 took a			and the Assistant Director of		
					Nursing.		
	picture and text	it to CNA #3's cell phone.			- what measures will be p	ut I	
					into place or what systemic		
		mation, sent to ISDH on			changes will be made to ensu	re	
	8/6/12 indicated	"CNA, #1, reported to			that the deficient practice does		
	the Administrate	or on 8/6 at 2:00 p.m.,			not recur;		
	CNA #2 had sho	owed her, CNA #1, a					
		#2's phone of a bruise on			Both CNA's involved in the	_	
		osterior left upper thigh.			incident were terminated. Sta was in-serviced regarding cell		
	•	on, it was verified by			phone, resident rights, and		
	_	ember that CNA #2,			photograph policies on 8/15/2	<sub>012.</sub>	
					1		
	_	e of this bruise, to two					
		3, stated that 'I held up the			- how the corrective action		
		hile CNA #2 took the			will be monitored to ensure the		
	_	A #2 text the picture to			deficient practice will not recui	Γ,	
	my cell phone.'				program will be put into place;	.	
					and	'	
	A undated, police	cy provided by the					
	•	n 8/7/12 at 3:10 p.m.,			Continuous Quality Improvem	ent	
		1 /	- 1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN O	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155625	B. WING		08/07/2012
AND PLAN O	ROVIDER OR SUPPLIER SROVE VILLAGE  SUMMARY S  (EACH DEFICIEN  REGULATORY OR  indicated "Telep  Phones", "The u  cell phones is no working hours u  the use of such a these devices co disciplinary actio "Camera Phones	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) hones/Pagers/Cell se of personal pagers or of permitted during nless your job requires a device. Caught using uld be grounds for on." "", "The Company	A. BUILDING B. WING STREET 1021 E	ADDRESS, CITY, STATE, ZIP CODE CENTRAL AVE NSBURG, IN 47240  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)  monitoring tool will be used to monitor staff adherence to cell phone policies monthly for 3 months and then quarterly for quarters by Executive Director designee. This will be reviewed by the Quality Assurance Tear Cell phone usage will be monitored by Nurses and Supervisors during regular face	COMPLETED 08/07/2012  (X5) COMPLETION DATE  3 or ed m.
	cameras in the w camera phones, a believed necessa privacy, trade se information. Th phone feature of prohibited at all used on compan- these devices wi action; up to and "Photographs", ' photographed ur permission form know what they protect the reside persons, media, take photographs Director/Directo manager/Clinica During an interv p.m., DON (Dire indicated staff at cell phone while	vee possession or use of vorkplace, including as a preventative step ary to secure employee crets and other business in use of the camera are any cell phone is strictly times and is never to be any property. Caught using all result in disciplinary are including termination."  The Residents must not be alless they have signed a and are cognizant to are approving. To ent's rights, refer outside for others who want to see to the Executive are of Nursing/General and Director."  The won 8/7/12 at 3:20 ector of Nursing) are not permitted to have a they are working. Staff put their cell phone in		walk through and observation all 3 shifts.  - by what date the system changes will be completed.  Completion date will be 08/25/2012.	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 08/07/2012
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE  CENTRAL AVE	
ARBOR (	GROVE VILLAGE			ISBURG, IN 47240	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	their purse or in locker.	the CNA room in their			
	3.1-3(o)				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		155625	B. WIN			08/07/2012	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				CENTRAL AVE		
ARBOR (	GROVE VILLAGE				ISBURG, IN 47240		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0224	483.13(c)						
SS=D	PROHIBIT	- (NUE OL E OT (NUE A DDD OD					
	RIATN	T/NEGLECT/MISAPPROP					
		develop and implement					
	_	nd procedures that prohibit					
		glect, and abuse of					
		sappropriation of resident					
	property.						
	Based on record	review and interview the	F02	24	- what corrective action(s)	will	08/25/2012
	facility failed to	ensure 1 resident did not			be accomplished for those		
	experience mistr	eatment for 1 of 9			residents found to have been		
	*	nple of 5 reviewed for			affected by the deficient practic	ce;	
	mistreatment. (F	*			The two CNA's involved were		
	inisticatificit. (I	Cesident #D)			terminated from the facility. The	he	
					family and physician of the	10	
	Findings include				affected resident were notified		
					The affected was unaware the	;	
	Resident #D's re	cord was reviewed on			incident occurred and the incident		
	8/7/12 at 12:30 p	o.m.			has had no negative effects or	1	
					the affected residents		
	Resident #D's M	DS (Minimum Data Set),			psychosocial well-being.		
		cated Resident scored 0					
	on the	<b>3</b>			- how other residents havi	ina	
		For Mental Status with a			the potential to be affected by		
					same deficient practice will be		
		cating severe impairment.			identified and what corrective		
		ndicated Resident #D was			action(s) will be taken;		
		t for transfers, unable to			All regidents are at rick of bein	.~	
	walk, and her fur	nctional status was totally			All residents are at risk of bein affected by the alleged deficien	•	
	dependent.				practice. Staff was in-serviced		
					regarding cell phone, resident		
	During an interv	iew on 8/7/12 at 10:00			rights, and photograph policies		
	_	istrator indicated CNA			8/15/2012 by Director of Nursi	ng	
		her of CNA #2 taking a			and the Assistant Director of		
		ent #D's left upper thigh			Nursing.		
		one while CNA #3 held			- what measures will be p	ut	
	•				into place or what systemic	ut	
	Resident #D's le	g up to take a picture of a			Into pidoo or what by storillo		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO		(X3) DATE SURVEY  COMPLETED		
ANDILAN	or connection	155625	A. BUILDING	00	08/07/2012		
		100020	B. WING	A DED DEGG GYENY GENERAL GENERAL GODE	00/01/2012		
	PROVIDER OR SUPPLIE GROVE VILLAGE	R	STREET ADDRESS, CITY, STATE, ZIP CODE  1021 E CENTRAL AVE  GREENSBURG, IN 47240				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	_	g and after CNA #2 took ext it to CNA #3.		changes will be made to ensu that the deficient practice doe not recur;			
	3.1-28(a)			Both CNA's involved in the incident were terminated. Stawas in-serviced regarding celphone, resident rights, and photograph policies on 8/15/2	I		
				- how the corrective action will be monitored to ensure the deficient practice will not recuive, what quality assurance program will be put into place and	ne ir,		
				Continuous Quality Improven monitoring tool will be used to monitor staff adherence to ce phone policies monthly for 3 months and then quarterly for quarters by Executive Director designee. This will be review by the Quality Assurance Tea Cell phone usage will be monitored by Nurses and Supervisors during regular fa walk through and observation all 3 shifts.	or 3 or o		
				<ul> <li>by what date the syster changes will be completed.</li> <li>Completion date will be 08/25/2012.</li> </ul>	nic		

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			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
		155625	B. WIN			08/07/2012	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				CENTRAL AVE		
	GROVE VILLAGE				ISBURG, IN 47240		
ARBOR				GREEN	NSBURG, IN 47240		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	A83.13(c) DEVELOP/IMPLM ETC POLICIES The facility must of written policies are mistreatment, negresidents and mister property. Based on record facility failed to procedure to procedure to procedure to procedure to procedure to procedure the procedure to procedure t	MENT ABUSE/NEGLECT,  develop and implement and procedures that prohibit glect, and abuse of sappropriation of resident  review and interview the follow their policy and tect 1 resident's privacy ty in a sample of 9.	F02	TAG	- what corrective action(s) be accomplished for those residents found to have been affected by the deficient practic.  The two CNA's involved were terminated from the facility. The family and physician of the affected resident were notified. The affected was unaware the incident occurred and the incidents had no negative effects on the affected residents psychosocial well-being.  - how other residents havi the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken;  All residents are at risk of bein affected by the alleged deficient practice. Staff was in-serviced.	will ce; ne lent n ng the	
	a.m., the Admini #3 had informed picture of Reside	iew on 8/7/12 at 10:00 strator indicated CNA her of CNA #2 taking a ent #D's left upper thigh one while CNA #3 held			regarding cell phone, resident rights, and photograph policies 8/15/2012 by Director of Nursil and the Assistant Director of Nursing.  - what measures will be pure the property of the proper	ng	
	•	g up to take a picture of a			into place or what systemic changes will be made to ensur	е	

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 OF CORRECTION	IDENTIFICATION NUMBER:  155625	A. BUII	LDING	00	COMPLETED 08/07/2012	
bruise on her leg the picture she te A undated. policy Administrator on indicated "Teleph Phones", "The use cell phones is not working hours ut the use of such a these devices coudisciplinary action "Camera Phones" prohibits employ cameras in the we camera phones, a believed necessal privacy, trade see information. The phone feature of prohibited at all the used on company these devices will action; up to and "Photographs", "photographed un permission form know what they a protect the reside persons, media, of take photographs."	ratement of deficiencies CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)  and after CNA #2 took ext it to CNA #3.  by provided by the 18/7/12 at 3:10 p.m., hones/Pagers/Cell se of personal pagers or t permitted during heless your job requires device. Caught using hild be grounds for on."  ", "The Company he possession or use of orkplace, including has a preventative step hry to secure employee herets and other business he use of the camera hany cell phone is strictly himmes and is never to be hy property. Caught using has result in disciplinary hincluding termination."  Residents must not be heless they have signed a hand are cognizant to hare approving. To honer's rights, refer outside hor others who want to have to the Executive has rof Nursing/General	B. WIN	STREET A 1021 E	ADDRESS, CITY, STATE, ZIP CODE CENTRAL AVE ISBURG, IN 47240  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)  that the deficient practice does not recur;  Both CNA's involved in the incident were terminated. Staff was in-serviced regarding cell phone, resident rights, and photograph policies on 8/15/20  - how the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; and  - Continuous Quality Improveme monitoring tool will be used to monitor staff adherence to cell phone policies monthly for 3 months and then quarterly for quarters by Executive Director designee. This will be reviewed by the Quality Assurance Tear Cell phone usage will be monitored by Nurses and Supervisors during regular fact walk through and observation all 3 shifts.  - by what date the system changes will be completed.  Completion date will be 08/25/2012.	off  112.  (s)  ent  3  or  ed  m.  ility  on	(X5) COMPLETION DATE
		<u> </u>				

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	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	00 		LETED
		155625	B. WING			7/2012
	PROVIDER OR SUPPLIER		1021 E	ADDRESS, CITY, STATE, ZIP CO CENTRAL AVE ISBURG, IN 47240	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	p.m., DON (Dire indicated staff ar cell phone while are supposed to	iew on 8/7/12 at 3:20 ector of Nursing) re not permitted to have they are working. Staff put their cell phone in the CNA room in their				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE ( A. BUILDING	(X3) DATE SURVEY COMPLETED		
		155625	B. WING		08/07/2012
	PROVIDER OR SUPPLIE	R	1021 8	ADDRESS, CITY, STATE, ZIP CODE E CENTRAL AVE NSBURG, IN 47240	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0241 SS=D	in a manner and maintains or enh dignity and respector her individualist Based on record facility failed to of 9 residents resample of 9. (Findings including Resident #D's resident #D's resident #D's Nassessment, indon the Brief Interview score of 0-7 ind The MDS also it totally dependent walk, and her fundered walk, and her fundered a.m., the Admin #3 had informed picture of Resident #D's lessident #D's les	promote care for residents in an environment that ances each resident's ect in full recognition of his ty.  I review and interview the ensure the dignity for 1 eviewed for dignity in a Resident #D)  e:	F0241	- what corrective action(s be accomplished for those residents found to have been affected by the deficient praction. The two CNA's involved were terminated from the facility. The family and physician of the affected resident were notified. The affected was unaware the incident occurred and the incidents had no negative effects of the affected residents psychosocial well-being.  - how other residents have the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken;  All residents are at risk of being affected by the alleged deficient practice. Staff was in-serviced regarding cell phone, resident rights, and photograph policies 8/15/2012 by Director of Nursing.  - what measures will be point on place or what systemic changes will be made to ensure.	ce; he l. dent n ing the ds on ing ut

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PRINTED: 08/30/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155625	A. BUILDING  B. WING		COMPLETED  08/07/2012
	PROVIDER OR SUPPLIER GROVE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE  1021 E CENTRAL AVE  GREENSBURG, IN 47240		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5)  COMPLETION DATE	
		LSC IDENTIFYING INFORMATION)		CROSS-REFERENCED TO THE APPROPRIA	off DATE  Solution (S)  ent  a solution (S)  ent  d solution (S)  ent  ent  d solution (S)  ent  ent  d solution (S)  ent  ent  ent  d solution (S)  ent  ent  ent  ent  ent  ent  ent  en
				walk through and observation all 3 shifts.  - by what date the system changes will be completed.  Completion date will be 08/25/2012.	on

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2E1S11

Facility ID: 000305

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